



Healthcare in Egypt's Border Regions: When Money Is Not Enough

SHERIF MOHYELDEEN

The coronavirus pandemic is testing health systems around the world. Egypt's system is no exception to this rule, particularly in some of its border regions where there are not enough qualified doctors to operate what life-saving equipment there is. As a result of the country's overly centralized health system, most of its resources have been spent in Cairo, Alexandria, and other populous cities in the Nile Valley. This has left many border communities feeling marginalized, despite the large budgets allocated for improving health infrastructure in their regions.

However, even more than money, it is the quality of healthcare that is the issue. Egypt's border inhabitants believe that the standard of healthcare in their areas is inferior to that provided in cities of the Nile Valley. And there are signs that this may be true. While the state has invested in health by building hospitals and paying higher salaries on average to doctors in border areas, it has failed to improve other aspects of healthcare, such as guaranteeing the presence of qualified doctors and creating conditions for them to work and remain in

these areas. Thus, the primary problem appears to be authorities' mismanagement of the system rather than intentional neglect.

TWO CONTENDING NARRATIVES OF HEALTH SERVICES

There are two contrary narratives regarding the condition of health services in Egypt's border areas. The first narrative is widespread among [border communities](#) and portrays the shortcomings in health services as an extension of the state's marginalization of the borderlands. This derives from a historical sense of injustice felt by populations of the periphery in one of the oldest centralized states in the world. In contrast, the state's version is that health services are excellent in border areas, indeed [better than in many other areas of Egypt](#), and that any problems are due to financial shortages. Defenders argue that despite these shortages, the state under President Abdel Fattah el-Sisi has done its best by spending hundreds of millions of Egyptian



pounds on developing health sectors near the borders. They point to investments in new facilities, including the 140 million pounds (\$9 million) spent on building a new hospital in Aswan in 2014, the 100 million pounds (\$6.4 million) to build the Shalateen Central Hospital that opened in 2017, and the 15 million pounds (\$1 million) to develop a healthcare center west of the Aswan Dam in 2020.

According to the government, for years before the coronavirus pandemic, the ratio of doctors to the population had been higher in the five border governorates (Aswan, Matrouh, New Valley, North Sinai, and South Sinai) compared to Egypt's remaining governorates. However, border communities point out that the number of doctors serving in the border areas is artificially inflated, and many of those who do serve are getting paid elevated salaries while rarely being physically present. Such corrupt practices likely aim to counter a general trend of doctors seeking to improve their relatively insufficient revenues, including by searching for better opportunities in the private sector.

Local communities point to a history of neglect. For instance, while there are currently thirty-two faculties of medicine—in addition to four faculties under Al-Azhar University and one under the army—across eighteen governorates in Egypt, not one existed in any of the five border governorates until 2013. That is when then-president Mohammed Morsi established a faculty of medicine in Aswan through a presidential decree. Furthermore, in terms of hospital numbers, three border governorates had the lowest numbers of hospitals in Egypt in 2017.

In July 2020, Prime Minister Moustafa Madbouly announced in Aswan that investment in the health sector is a government priority. Among other measures, the authorities seek to establish a universal health insurance system, supported by \$400 million from the World Bank. As a first step, the system was introduced in six governorates regarded as on the periphery of the state—Aswan, Ismailia, Luxor, Port Said, South

Sinai, and Suez—and should cover all of Egypt by 2032. It's unclear how communities in the two border governorates (Aswan and South Sinai) perceive this system, as public awareness remains low and historical mistrust of the regime still dominates the discourse. Generally, the state rarely acknowledges the past marginalization of border communities, while these communities remain persuaded that the government is intentionally disregarding them. The truth lies somewhere in the middle.

A FAILURE TO MATCH AMBITIONS WITH MEANS

The health situation in the border governorates is hardly as straightforward as local inhabitants or the government have sought to depict it. Both narratives are based on some facts and some omissions. While the state has put money into the health sector, this has not translated into higher standards of care for patients. Whether it is the numbers of doctors present or the quality of services they provide or the conditions in which they work, good intentions apparently have been undermined by poor implementation and follow through.

After the uprising in 2011, Egyptian governments spent substantial amounts of money on the health sector, including developing infrastructure in the country's borderlands. However, basic questions—such as where the money is going, how it is being spent, and whether it allows for sustainability in the sector—must be asked to determine whether the governments' efforts have been effective in reversing a historical feeling of marginalization among border populations.

The current government's intention to spend more on health, particularly in disadvantaged areas, has been evident in recent months. In February 2020, after the coronavirus outbreak, Madbouly declared that the government would be doubling the Ministry of Health and Population's budget in 2020–2021, continuing a pattern of raising health sector budgets. It is revealing

that the government is testing its universal healthcare system in the [six governorates](#) regarded as being on the periphery of the state. For this first stage, the government has [allocated](#) about 23.5 billion Egyptian pounds (\$1.5 billion) to the development of health infrastructure in these governorates and another 10 billion pounds (\$640 million) on its operation.

However, until the new system is fully functional throughout Egypt and its effectiveness can be assessed, the current health system and its challenges will continue to prevail in border areas. One significant challenge is that public sector physicians continue to have little motivation to work in border areas. Though doctors there earn at least double the salaries of physicians in public hospitals and medical centers in the country's capital, Cairo, these revenues are insufficient to guarantee an adequate standard of living. Indeed, millions of government employees throughout Egypt are obliged to take on second jobs to provide for their families.

In March 2020, to address this problem—and to mitigate the effects of the coronavirus pandemic—Sisi ordered a 75 percent increase in monthly allowances to all medical professionals at the health ministry ([for a total price tag of 2.25 billion](#) Egyptian pounds (\$140 million)). Although the sum may seem substantial, its impact is likely to be minimal as the increases would range from 400 to 700 pounds per health professional ([\\$26 to \\$45](#)).

The substandard quality of healthcare in border regions and the inadequate working and living conditions of medical personnel are two major reasons why the increases in government spending have failed to persuade the inhabitants of these regions that they are not being neglected. This underlines how the government is failing to match its increased expenditures with proper planning and monitoring of the health sector, which points to shortcomings in terms of competence and management.

Hospitals and clinics in border areas are sometimes better equipped than those in other parts of Egypt, showing the state's desire to provide adequate capacity. However, a number of flaws are visible. The numbers of present doctors and competent staff are insufficient, and those that are present are not as well trained as their peers elsewhere. Moreover, little is done to attract qualified doctors or to make their lives more appealing so that they might extend the duration of their service. This would ensure the continuity, and therefore the sustainability, of health systems in border areas.

The first problem is that the number of doctors working for national hospitals and government clinics under the health ministry is dropping. This is happening for many reasons, including much lower salaries in the public sector than the private sector, a decaying medical infrastructure, and, now, inadequate safety precautions in the treatment of COVID-19 patients. The number of doctors has [declined by over 30 percent](#)—from 113,000 in 2014 to 76,000 in 2018. This means that no more than 38 percent of Egyptian doctors work for the ministry, compared to 62 percent who have either [left government employment](#) to emigrate or who have entered private practice. Other doctors have opted to take long leaves of absence from the ministry.

At the same time, there are sharp differences in the distribution of doctors among the country's peripheries and the center. Not only are there more doctors in Cairo than in the border regions, but there are also more in the main cities of border [governorates](#) than in their surrounding villages. This imbalance is one reason why border populations living outside urban areas feel they are not benefiting from government spending on health.

A second problem has to do with the quality of doctors, which is a result of the way the health system operates. Most doctors graduating from medical faculties at Egyptian universities are obligated to serve for a year or two in a government hospital or health facility. A consequence of this is that many fresh graduates whose



grades do not allow them to pursue their medical specializations in the more sought-after hospitals in Cairo ask to be placed in hospitals in peripheral locations, such as border areas. The reason is that there is less competition to enter such establishments and they can earn relatively higher salaries. However, these doctors do not really have an opportunity to develop their skills through collaboration with experienced professionals, most of whom serve in private hospitals and clinics in the capital.

A notable outcome of these deficiencies is what is happening in the disputed Halayeb Triangle and Shalateen in the border region with Sudan. In August 2020, the inhabitants of Shalateen repeatedly appealed to the Egyptian government for help amid the COVID-19 crisis, complaining that “[medical negligence](#)” was responsible for a rise in infections and deaths. The Shalateen hospital had purchased new ventilators to treat patients with the disease; however, there were no qualified doctors to run the equipment, so patients were left to die unnecessarily.

There are also disincentives that explain why doctors have little motivation to work in and stay in peripheral locations. Among the more prominent of these are the poor quality of accommodations, which are not designed to allow doctors to bring family members with them; the questionable quality of schools in these locations; and poor transportation infrastructure, which makes movement difficult and costly. Together, these problems counter the effects of the government’s expenditures on border health facilities. Improvements in the standards of such facilities need to be accompanied by improvements in the quality of healthcare through the proper training and distribution of competent doctors throughout the medical system. More attractive living conditions for medical staff would help advance such goals.

In sum, the state has created a situation in which it is working at cross-purposes in border areas. On the one hand, it is striving to ensure that the regions’ populations have the proper health infrastructure. On the other hand, it is failing to provide and support medical professionals who can optimize the advantages of this infrastructure. This disconnect strongly implies a lack of organizational capability rather than a conscious effort to deny border inhabitants an opportunity to benefit from proper healthcare. The difficulty is that for those living near the borders, such nuances are lost, which has only reinforced their conviction that they are being sidelined.

CONCLUSION

A potential alternative future exists for healthcare facilities in border areas. In the southern border city of Aswan, the Aswan Heart Center’s (AHC) success has shown that nonprofit organizations’ investment in border areas can lead to sustainable, high-quality treatment. This reality has provided a viable alternative to public investment, which tends to focus on health efforts away from peripheries. The AHC not only serves the local population but also attracts patients from across the country and [performs](#) around 1,100 open heart operations annually. The facility was established by the Magdi Yacoub Foundation and is led by the renowned Egyptian heart surgeon Dr. Magdi Yacoub. With this support, the AHC strives to meet international standards and the needs of qualified doctors, creating a more sustainable level of high quality.

Facilities similar to the AHC can go a long way toward creating a sense of inclusiveness among border populations. The Egyptian state needs to do more to combat perceptions of marginalization among communities in these regions, which have endured

decades of neglect under previous regimes. Such perceptions can, in certain situations, have implications for national security and stability. Nowhere is this truer than in the North Sinai border region, where feelings of marginalization have **contributed** to fueling a decade-long insurgency.

With regard to healthcare, the Egyptian government has to introduce incentives and training opportunities for doctors to work and remain in border areas and improve their skills there. It must also encourage sustainable initiatives that can permit health systems in border areas to renew themselves. This will facilitate the emergence of medical facilities that can adapt more flexibly to local needs by bringing together advanced infrastructure and professional competence.

ABOUT THE AUTHORS

Sherif Mohyeldeen is a nonresident scholar at the Malcolm H. Kerr Carnegie Middle East Center in Beirut, where his research focuses on Egyptian and North African cross-border issues.

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NOTES

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